PATIENT INFORMATION FORM

Patient Name: (Last)_____(First)_____(MI)__

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Cellular Phone: _____**Home or Alternate Phone**: _____

Date of Birth: _____Age: _____Sex: M F

Social Security: _____Driver's License: _____

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone No: _____Ext. _____

How Did You Hear About Us:

☐ Internet ☐ Email ☐ Location/Sign ☐ Phonebook ☐ Other (please specify)_____

☐ Doctor Referral (please specify who so we can send a Thank You)_____

☐ Patient Referral (please specify who so we can send a Thank You)_____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

FINANCIAL POLICY

Thank you for selecting Doctor Rx Weight Loss, L.L.C. for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience, we accept Cash, Checks, Visa, MasterCard, American Express and Discover.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient's Signature Date

MEDICAL HISTORY FORM

Name: _____ Age:_____ Sex: M F

Family Physician: _____ Phone: _____

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what? _____

3. Are you taking any medications at the present time? Yes No
   What: _____ Dosages: _____
   What:_____ Dosages: _____

4. Any allergies to any medications? Yes No
   _____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   At what age: _____

7. History of Heart Attack or Chest Pain? Yes No

8. History of Swelling Feet? Yes No

9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medications for Headaches: _____

10. History of Constipation (difficulty in bowel movements)? Yes No

11. History of Glaucoma? Yes No

12. Gynecologic History:
    Pregnancies: Number: _____ Dates: _____
    Natural Delivery or C-Section (specify): _____
    Menstrual: Onset: _____
    Duration: _____
    Are they regular: Yes No
    Pain associated: Yes No
    Last menstrual period: _____

    Hormone Replacement Therapy: Yes No
    What: _____
    Birth Control Pills: Yes No
    Type: _____
    Last Check Up: _____

13. Serious Injuries: Yes No
Specify: _____ Date: _____

14. Any Surgery: Yes No
Specify: _____ Date: _____
Specify: _____ Date: _____

15. Family History:

	Age	Health	Disease	Cause of Death	Overweight
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative ever had any of the following:

Glaucoma: Yes No Who: _____
Asthma: Yes No Who: _____
Epilepsy: Yes No Who: _____
High Blood Pressure Yes No Who: _____
Kidney Disease: Yes No Who: _____
Diabetes: Yes No Who: _____
Tuberculosis: Yes No Who: _____
Psychiatric Disorder Yes No Who: _____
Heart Disease/Stroke Yes No Who: _____

Past Medical History: (check all that apply)

_____ Polio	_____ Measles	_____ Tonsillitis
_____ Jaundice	_____ Mumps	_____ Pleurisy
_____ Kidneys	_____ Scarlet Fever	_____ Liver Disease
_____ Lung Disease `	_____ Whooping Cough	_____ Chicken Pox
_____ Rheumatic Fever	_____ Bleeding Disorder	_____ Nervous Breakdown
_____ Ulcers	_____ Gout	_____ Thyroid Disease
_____ Anemia	_____ Heart Valve Disorder	_____ Heart Disease
_____ Tuberculosis	_____ Gallbladder Disorder	_____ Psychiatric Illness
_____ Drug Abuse	_____ Eating Disorder	_____ Alcohol Abuse
_____ Pneumonia	_____ Malaria	_____ Typhoid Fever
_____ Cholera	_____ Cancer	_____ Blood Transfusion
_____ Arthritis	_____ Osteoporosis	_____ Other: _____

Nutrition Evaluation:

1. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____
2. In what time frame would you like to be at your desired weight? _____
3. Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____
4. What is the main reason for your decision to lose weight? _____
5. When did you begin gaining excess weight? (Give reasons, if known): _____

   _____
6. What has been your maximum lifetime weight (non-pregnant) and when?_____
7. Previous diets you have followed: Give dates and results of your weight loss:

   _____ _____

   _____ _____
8. Is your spouse, fiancée or partner overweight? Yes No
9. If yes, by how much is he/she overweight? _____
10. How often do you eat out? _____
11. What restaurants do you frequent?_____
12. How often do you eat "fast foods?"_____
13. Who plans meals? _____ Cooks? _____ Shops? _____
14. Do you use a shopping list? Yes No
15. What time of day and on what day do you shop for groceries? _____
16. Food allergies: _____
17. Food dislikes: _____
18. Food you crave: _____
19. Any specific time of the day or month do you crave food? _____
20. Do you drink coffee or tea? Yes No How much daily? _____
21. Do you drink cola drinks? Yes No How much daily? _____

22. Do you drink alcohol? Yes No
What? _____ How much? _____ Weekly? _____

23. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

24. Do you awaken hungry during the night? Yes No

What do you do? _____

25. What are your worst food habits? _____

26. Snack Habits:

What? _____ How much? _____ When? _____

_____ _____ _____

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

_____

_____

28. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

_____

29. Smoking Habits: **(answer only one)**

- ❑ You have never smoked cigarettes, cigars or a pipe.
- ❑ You quit smoking _____ years ago and have not smoked since.
- ❑ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
- ❑ You smoke 20 cigarettes per day (1 pack).
- ❑ You smoke 30 cigarettes per day (1-1/2 packs).
- ❑ You smoke 40 cigarettes per day (2 packs).

30.

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

31. Describe your usual energy level: _____

32. Activity Level: **(answer only one)**
- ❑ Inactive – no regular physical activity with a sit-down job.
- ❑ Light activity – no organized physical activity during leisure time.
- ❑ Moderate activity – occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- ❑ Heavy activity – consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
- ❑ Vigorous activity – participation in extensive physical exercise for at least 60 minutes per session, 4 times per week.

33. Behavior style: **(answer only one)**
- ❑ You are always calm and easygoing.
- ❑ You are usually calm and easygoing.
- ❑ You are sometimes calm with frequent impatience.
- ❑ You are seldom calm and persistently driving for advancement.
- ❑ You are never calm and have overwhelming ambition.
- ❑ You are hard-driving and can never relax.

34. Please describe your general health goals and improvements you wish to make: _____

_____

_____

_____

35. Do you filter your drinking water? Yes No

36. Do you ionize your drinking water? Yes No

37. Do you have full spectrum lighting in your home/office? Yes No

38. Do you use your computer or mobile phone late in the evening? Yes No

39. Are you exposed to EMF's at home or work (i.e. computers, cellphones, electronic devices, microwave, etc.)? Yes No

40. Do you get 6.5 to 8 hours of sleep per night? Yes No

41. Do you filter the air in your office or home? Yes No

42. Do you ionize the air in your office or home? Yes No

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

PATIENT CONSENT FOR APPETITE SUPPRESSANTS

I. Procedure and Alternatives:

I_____ (patient or patient's guardian) authorize Dr Ford of Doctor Rx Weight Loss, L.L.C. to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

1. I have read and understand my doctor's statements that follow:

"Medication, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressants labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling."

"As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger does than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggest, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses."

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below)."

"As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risk of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

2. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

3. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

4. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange-eating program without the use of appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risk of Proposed Treatments:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include; nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication, allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious risks are primary pulmonary hypertension and vascular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risk Associated with Being Overweight or Obese:

I am aware the there are certain risk associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and no arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTION WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE: _____ TIME: _____

PATIENT: _____WITNESS: _____

(or person with authority to consent for patient)

VI. Physician Declaration:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

Physician's Signature_____

WEIGHT LOSS PROGRAM POLICY

I understand that if I develop any side effects from the Doctor Rx Weight Loss, L.L.C program, I will stop the diet and/or medication and notify the doctor at Doctor Rx immediately. If the problem is severe, I will go to the Emergency Room immediately.

There is no guarantee the program will work for me you. By signing below, you certify you have read and fully understand this consent form. You should not sign this form if you have any questions or concerns that have not been answered to your complete satisfaction. Your signature further confirms that you do not have a history of alcohol abuse, drug abuse, schizophrenia, or manic-depressive illness or a history of any eating disorder since these conditions are a contradiction to the use of appetite suppressants. You agree not to take any other appetite suppressants, other medications or injections other than those prescribed by the Doctor Rx doctor or listed and approved on your medical history form. You will inform the doctor of any change in your medication.

I understand that the Doctor Rx Weight Loss program, all written materials describing the program or any of its parts, applicable trademarks, copyrights and other intellectual property in or our program are and remain our absolute property. You acknowledge that you are purchasing a non-exclusive, non transferable license to use our program and the related written materials for your own use, and that you have no right to duplicate or to sell, lend or transfer in any way to any other person the use of our program or written materials.

Again, thank you for selecting Doctor Rx Weight Loss for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience, we accept Visa, MasterCard, American Express, Discover, checks and cash. You understand that our services are not reimbursed by insurance, and we do not provide or fill out claim forms for insurance. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs. You also understand that no refunds will be given at any time for any reason. I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient Date

_____

Witness

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

"This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Get Access To This Information." Please Review It Carefully.

We Safeguard Information about Your Health and Person:

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of the computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians and billing personnel. We may use your medical information for treatment and care, and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses), billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, products recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provide authorization is IRB-approved or privacy board-approved
- Specialized government functions (military, inmates)
- Worker's compensation
- Disaster relief and fundraising

We will not use or disclose your medical information for any purpose not listed without specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

PATIENT PRIVACY RIGHTS

You have the right to:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your information to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last six years. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosures noted above. You may revoke or restrict consent.
- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy of the notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

We may contact you for appointment reminders, and we may provide you with information about health-related or product benefits and services. Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibilities under HIPAA:

We are required by law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

You can complain about our privacy policy or its execution either verbally or in writing to our office. If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services. Effective Date: April 14, 20003

PRIVACY NOTICE RECEIPT

I have read and/or requested a copy of Doctor Rx Weight Loss privacy notice as required by HIPPA.

Signature: _____Date: _____

Patient's Printed Name: _____

Witness: _____Date: _____

RELEASE OF MEDICAL RECORDS

I give permission for my medical records (blood work, chart, EKG) to be released to:

DOCTOR RX WEIGHT LOSS, L.L.C

2828 SOUTH TAMIAMI TRAIL

SARASOTA, FL 34239

PHONE (941) 957-0200

FAX (941) 953-7883

Printed Name _____

Signature _____

Date _____

WEIGHT-LOSS CONSUMER BILL OF RIGHTS

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Consult your personal physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program; know the name, address and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to s.468-505(1)(j), Florida Statutes.

Required to be posted by section 501.0575 of Florida Statutes

I have read the above:

Patient's Signature _____ Date _____

WEIGHT LOSS PROGRAM CONSENT FORM

I _____ authorize Dr. Robert.E. Ford & Doctor Rx weight Loss, L.L.C and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ **Time:** _____

Witness: _____ **Patient:** _____
(Or person with authority to consent for patient)

THE "MODEL" RELEASE FORM

1. The "Model" _____hereby grants to Doctor Rx Weight Loss, L.L.C. ("Photographer"), his/her heirs, legal representative, and assigns, for whom Photographer is acting, and those acting, with his/her authority and permission (hereinafter collectively referred to as the "Users"), the irrevocable and unrestricted right and permission to take, use, publish, and republish photographic portraits, video images with voice or pictures of the Model including, with limitation, reproductions thereof in which the Model may be included, in whole or in part (hereinafter collectively referred to as the "Photographs") in exchange for $1.

2. The Photographs may be used for illustrations, promotion, art, editorial, advertising, trade, in form including but not limited to television and motion pictures, magazines, books, video recordings, audio recordings or other media, known or unknown at this time, or any other lawful purpose whatsoever.

3. The Model hereby waives any right to inspect or approve the finished product or products and the advertising copy or other matter that may be used in conjunction therewith or the use to which it may be applied.

_____	_____	_____
Model Name Printed	Model Signature	Date

_____	_____	_____
Witness Name Printed	Witness Signature	Date

CONFIDENTIALITY AGREEMENT

The undersigned reader acknowledges that the information provided herein pertaining to Doctor Rx Weight Loss, LLC in this business plan is confidential; therefore reader agrees not to disclose it without the express written permission of Doctor Rx Weight Loss, LLC.

It is acknowledged by reader that the information to be furnished in this business plan is in all respect confidential in nature, other than information which is the public domain through other means and that any disclosure or use of same by reader, may cause serious harm or damage to Doctor Rx Weight loss, LLC.

Upon request, this document is to be immediately returned to Doctor Rx Weight Loss, LLC.

_____ _____

Signature Witness

PATIENT CONTACT INFORMATION

On occasion, we will contact you regarding your weight loss program and ongoing promotions. To better serve you, please provide us with your email address and cell phone number.

Cell Phone:_____

Email:_____

Patient Name (Print):_____

Patient Signature:_____

Date:_____

Witness:_____